DEPARTMENT OF HEALTH
TENNESSEE BOARD OF PHARMACY
Controlled Substance Database Administrator
665 Mainstream Drive
NASHVILLE, TENNESSEE 37243
(615) 253-1305 OR FAX (615) 253-8782

PATIENT RELEASE OF INFORMATION REQUEST

Please provide the information requested below. (Print or Type)

Patient Information:

Full Name of Patient:	Maiden Name:
Street Address:	AKA:
City:	State:
Zip Code:	Telephone Number: ( )
Social Security Number:	Birth date:

Specific Time Period to be covered in report:

Start Date:	End Date:

Requestor Information

Name of Person Information will be released to:	Street Address:
City:	State:
Zip Code:	Telephone Number: ( )

This authorizes the above named person to request and receive from the Tennessee Controlled Substance Monitoring Database any and all records held by the Department relating to Schedule II-V controlled substances dispensed to the patient named above during the time frame listed.

I understand that this authorization permits the disclosure of confidential health care records to the person named above. There is a potential for any information disclosed, pursuant to this authorization, to be subject to re-disclosure as permitted or required by law.

I understand that, if not previously revoked, this consent will expire one (1) year after the date of my signature unless otherwise specified.

I,_____, do solemnly swear and affirm that I have personally completed this form, and that the information in the foregoing paragraphs is true and correct to the best of my knowledge.

_____
(Signature of Applicant)

Sworn to and subscribed before me this_____day of_____20_____.

My Commission expires_____.

_____
(Notary Public)

For Department Use Only

For Department Use Only Date Received	**Approved Disapproved**	**Director of Designee Signature**	**Date of Action**